MN DEPARTMENT OF HEALTH

PROVIDER PEER GROUPING (PPG) ADVISORY GROUP

- DRAFT REPORT
- REVIEW OUTSTANDING ISSUES
- INFORMATION NEEDS FOR DIFFERENT AUDIENCES

ANN ROBINOW

MEETING 7: SEPTEMBER 2, 2009

PPG Advisory Meeting Schedule

MEETING	DATE	TOPIC
Meeting 1	Thursday, June 11	Introduction/Background
Meeting 2	Friday, June 26	Defining Parameters
Meeting 3	Friday, July 10	Cost Measure for Conditions
Meeting 4	Friday, July 17	Quality Measures for Conditions Cost Measure for Total Care
Meeting 5	Wednesday, July 22	f/u Quality Measures for Conditions Quality Measure for Total Care Combining Cost & Quality
Meeting 6	Monday, July 27	Combining Cost & Quality
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Introduction

- Comments and changes to meeting summary?
- Review of questions or comments since last meeting.
  - Diabetes analysis of composite measure will be presented at next meeting.
- Report Technical Panel responses since last meeting.
  - Pneumonia Process Quality Measure: *% of patients with pneumonia, age 65 and older, who were screened for pneumococcal vaccine status and were vaccinated prior to discharge, if indicated.*

Provider Peer Grouping Recommendations: Draft Report

- Executive Summary
  - List general recommendations addressing nine issues as required in law
  - List other general recommendations
  - Does not list specific quality measures; must reference body of report.
  - Will expand to include more context in final draft to be a "stand alone" document

Provider Peer Grouping Recommendations: Draft Report

- Report
  - I. Introduction (p5)
  - II. Background (p5)
  - III. Process (p6)
  - IV. Condition Specific Recommendations (p8)
  - V. Total Care Recommendations (p17)
  - VI. Combining Cost & Quality Recommendations (p24)
  - VII. Presenting Peer Grouping Data to Different Audiences (*to be discussed*)
  - VIII. Additional Recommendations (p27)
  - IX. Appendix (Advisory, Technical, Roadmap)

Draft Report: Next Steps

Review: Providers with Missing Quality Measure Data

- Issue: How will quality scores be calculated for providers who do not have data for all of the individual quality measures?
- MDH has consulted with additional experts to provide suggestions on how to address this issue.

Review: Providers with Missing Quality Measure Data Suggestions

- Provider should have data on at least one measure from each of following categories in order to be peer grouped:
  - structural
  - process
  - patient experience
  - outcome measures
  - A key consideration is to what extent a singular measure from each of these categories can adequately represent each type.
- For small providers with smaller numbers of observations, it is reasonable to combine data on similar types of measures (particularly process measures) in order to get the provider to sufficient numbers to include in the peer grouping analysis.
  - For example, group process measures into diagnostic screening processes and chronic disease monitoring processes and combine data within each of these categories as needed to get providers to the 30+ cases needed for reporting.

Review: Options for Weighting Quality Measures

- Current Recommendation: All quality measures be equally weighted unless information emerges that strongly indicates a particular measure is a better indicator of quality.
- MDH has consulted with additional experts to provide suggestions on potential weighting options and rationale for weighting measures differently. (*M. Pine Recommendation*).

Expert Advice on Combining Quality Measures—Michael Pine, PhD

- Create "nested" categories of intermediate composites
  - Create subcategories
  - Weight subcategory components into overall composite

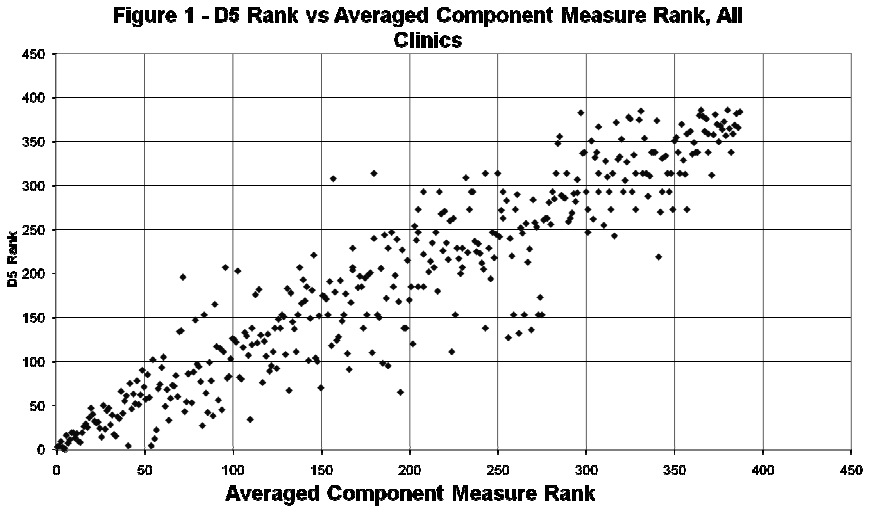
Expert Advice on Combining Quality Measures—Michael Pine, PhD

Condition Specific Quality	
65%	Measures of post discharge complications
35%	Composite of process measures

Total Care Quality	
20%	Prevention measures
10%	Minor acute care
10%	Chronic disease processes
20%	Chronic disease outcomes
30%	Hospital avoidance

Hospital Total Care Composite Measure (combined weighting)	
15%	Composite process measure
20%	Composite ER/Readmit outcome measure
30%	Composite hospital mortality measure
20%	Composite inpatient complication score
15%	Patient experience

Results of Follow Up on Disaggregation of D5 to Average Performance by Item



Review: Desired Attributes of Ranking Methodology

Allows the data to determine which providers are most similar and therefore should be peer grouped together rather than using pre-determined definitions for peer groups

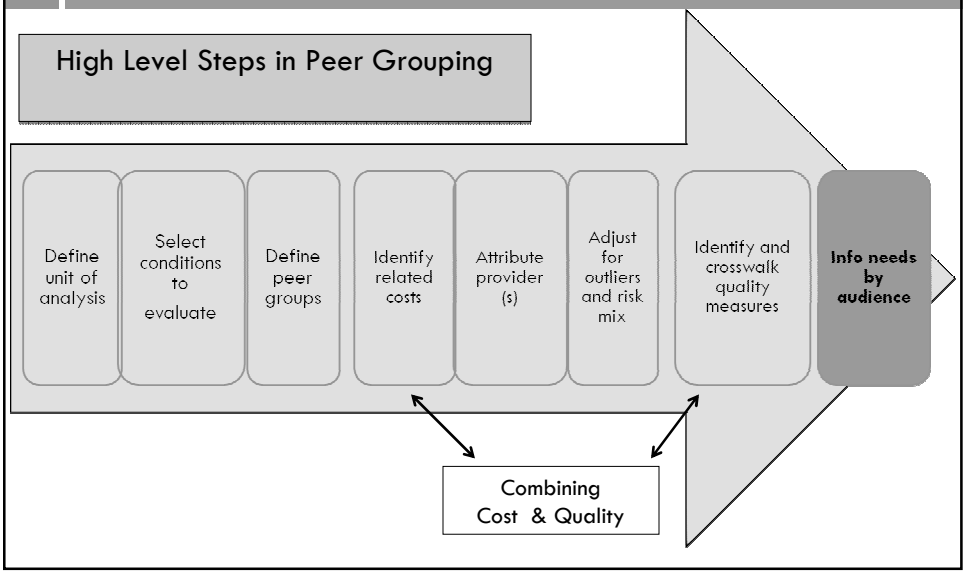
Allows the data to determine the natural number of peer groups based on similarities and differences

Cluster analysis is one methodology option to consider, as well as others, that meets the recommended attributes.

Does not force artificial differences to be drawn between providers that may appear to be on the cusp of two peer groups if using pre-determined definitions for peer groups

Does not require making a value judgment regarding the weight of cost versus quality to peer group providers

Context For Today's Discussion



Questions for Today's Meeting: Peer Grouping Information Needs by Audience

1. How can different audiences use the information and what *can't* the information be used for?
2. What specific types of information are needed by each user of the peer grouping? (providers, payer/purchaser, consumer)
3. What are issues associated with releasing detailed data to providers & plans?
4. What communication channels and data update frequency should be available?

Technical Panel Suggestions

Provider Considerations

- Most granular data possible but recognize patient identification will never be available ---clinic level aggregated data by service category *(Inpt, Outpt, MD, Rx, Ancillary)* could be acceptable.
- Data to allow verification of "patient attribution with greater confidence" should be provided to increase confidence in methodology.
- Provide all data on attributed patients to primary care provider for Total Care, including services not provided within system. Provide provider name, costs, volume by category.
- Ideally use data for care management but time lag will not allow.

Technical Panel Suggestions

Payers/Purchasers Considerations

- Collection of Quality data at community wide level will be valuable to payers/purchasers.
- Reporting of repriced cost data/resource use at community wide level will be valuable to payers/purchasers.
- Recognize plans will continue to negotiate different prices with same provider group; cost data will lag current contract terms and will not be reflective of any plans' actual pricing.

Technical Panel Suggestions

Consumer Considerations

- Caution too much cognitive burden on consumer to understand data will discourage use.
- Challenge to incorporate relevant pricing info for consumers.
- Consider media interpretation and influence on consumer.
- Interactive web based tool that allows for some user customization.
- Consider offering in English and Spanish; wait on others to determine necessity.

How can Peer Grouping Data be Used?

Useful For:	Providers	Payer/Purchasers	Consumers
Contracting	Yes	Yes	-----
Overall understanding of Relative Quality and Quality relative to Cost	Yes	Yes	Yes
Overall understanding of Resource Use	Yes	Yes	Yes
Overall understanding of Relative Cost	Yes	Yes	Yes
Specific impact of cost to user	No	No	No
Identifying efficient referral providers	Yes	Yes	-----
Selecting provider for specific condition	Yes	Yes	Yes
Care Management	No	-----	-----

What Specific Types of Data are Needed By Audience?

Data from Recommendations	Needed by Providers	Needed by Payer/Purchasers	Needed by Consumers
Quality by specific measures by composite score			
Actual Cost by service category by composite score			
by actual Payer Mix by Normalized Payer Mix			
Repriced Cost by service category by composite score			
by actual Payer Mix by Normalized Payer Mix			

Need for Detailed Data for Providers & Purchasers

Should MDH provide providers and/or purchasers a more detailed data set for analytic purposes?

Data Parameters:

- Encounter data will be updated every six months.
- Data will not be member identifiable; can not be easily matched back to provider or purchasers own data sets.
- Data must be in electronic format that can be easily imported.
- Data must be transported through a secure process.

Issues With Detailed Data Sharing

- MDH will ensure individual privacy protection if any claim level detail is provided.
- Data is missing some cost info—risk sharing, P4P, non-claim payments, may influence findings
- Data will contain a combination of reimbursement levels—won't actually reflect true costs by any plan
- May reveal some degree of competitive contracting info by plans
- Detailed data for providers will show variation in reimbursement levels among providers—may induce push for higher fee schedules
- Data will be retrospective and lagged—may not accurately reflect current status but will be used for future decisions

Level of Detail: Options

Aggregate Only

- Example:
  - Combined cost & quality score
  - Total Cost amount/score/relativity
  - Single quality score/relativity
- Simplifies amount of data to interpret
- Focuses users to common measures
- Less actionable for providers

Individual Components

- Example:
  - Individual quality measures
  - Components for hospital, MD, Rx that make up Total Cost
- Gives providers more actionable direction
- Can show areas of strength and weakness
- More specific data can be more relevant for user

Comparison Data: Options

Relativity Only

- Examples:
  - Group 5 of combined cost & quality
  - 1.2 > benchmark
  - .75 < quality benchmark
- Easier to interpret and understand data
- Minimum information required to be published under law
- Less actionable for providers

Dollar Value/ Quality Score

- Examples:
  - $250 pmpm for Total Care
  - $1600 per year for diabetes
- Consumer confusion with cost vs price on bill/claim
- Cost disclosure sensitivity
- Actual quality score is as meaningful to consumers
- More specific & detailed data

Total Care Cost Reporting Recommendations

Cost Data Reporting for Total Care			
	Providers	Payers/ Purchasers	Consumers
Show Cost Relativity			
Show Cost Amounts			
Show Aggregate Cost			
Show Cost Components			

Condition Specific Cost Reporting Recommendations

Cost Data Reporting for Conditions			
	Providers	Payers/ Purchasers	Consumers
Show Cost Relativity			
Show Cost Amounts			
Show Aggregate Cost			
Show Cost Components			

Total Care Quality Reporting Recommendations

Quality Data Reporting for Total Care			
	Providers	Payers/ Purchasers	Consumers
Show Quality Relativity			
Show Quality Score			
Show Composite Quality Score			
Show Individual Quality Measures			

Condition Specific Quality Reporting Recommendations

Quality Data Reporting for Conditions			
	Providers	Payers/ Purchasers	Consumers
Show Quality Relativity			
Show Quality Score			
Show Composite Quality Score			
Show Individual Quality Measures			

Modes of Communication

Web Site	Interactive Tool	Paper
• Efficient way to reach broad audience • Efficient way to update data • Technology barriers for some users	• Advantages of Web • Flexible, allows data to be most relevant for users • More complicated; requires education on how to use the tool • Technology barriers for some users	• Easy to reproduce and include with other documents, like open enrollment packages. • Easy to physically distribute (mail, open house) • No technology barriers • Higher cost • Harder to update

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